

ACCOUNTING OF DISCLOSURES REQUEST

Wyoming Department of Health

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), clients have a right to receive an accounting of all disclosures of their protected health information.

I hereby request an accounting of disclosures for:

Name:	ID Number (if applicable):
Date of Birth:	Address:
Date of Request:	City, State, Zip:
WDH will not list disclosures made more than three years prior to to. I, am requesting a list of disclosures for the following period of time:	-
(Signature) (Print Nam	ne) (Date)
*If not signed by the patient, please indicate the relationship: Guardian or conservator of an incompetent client Beneficiary or personal representative of deceased client Parent or guardian of minor client Other (specify)	For Office Use Only: Documentation of Relationship: Comments Reviewed Attached Date Processed: